STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006134	A. BUILDING: _____ B. WING _____	01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPTOWN HEALTH CENTER	4920 NORTH KENMORE CHICAGO, IL 60640

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S 000	Initial Comments Annual Licensure and Certification Survey. Complaint Investigations: 1980198/IL108567-no findings 1888111/IL108041-No Deficiency 1887985/IL107908- No Deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure that each resident receives adequate supervision to prevent accidents, for 1 resident in a sample of 35 (R5), who had a fall related incident that resulted in a head injury, which required emergency medical services; and failed to ensure that the resident environment remains free of potential accident hazards, by failing to properly dispose of sharp shaving equipment, for 2 of 35 residents in the sample (R248 and R82).	S9999		

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Findings include:
On 1/14/19 at 11:00 AM, R155 stated that while smoking on the smoking patio, R5 fell and "cracked" his skull and was bleeding profusely from the head. R155 stated that there was no staff on the smoking patio to supervise. R155 stated, "It's a shame he did not have any shoes on and it was too cold for that. He only had on those nonskid socks." R155 also stated, "There is almost never any staff to supervise residents on the smoking patio. Other residents come out there with gowns on, they pee and poop out there and everything. Some of these residents need more help than that because so many of them have psych issues and don't know what they are doing." R155 was asked to provide the times when is the smoking patio open. R155 stated, "It closes from 2:00 AM until 6:00 AM. R155 was asked, does staff supervise the smoking patio at 12 midnight. R155 stated, "Not all the time, mostly not."

On 1/14/19 at 11:45 as resident was being prepared for transport to the local emergency room, he was placed on the gurney by EMS (Emergency Medical Services) staff. After R5 was placed on the gurney, staff was observed taking off R5's nonskid socks which were wet and black. R5's toes were also black with unknown debris.

On 1/15/19 at 10:50 AM, no staff was observed on the smoking patio where 5 residents were smoking. During an interview on 1/15/19 at 11:00 AM, V31 (Smoking Monitor) was asked if he was supervising the smoking patio from 10:30 am to 11:00 am on 1/14/19. V31 stated, "Yeah, but I was not here when the resident fell and busted his head. I went to take a resident upstairs and when I came back he was trying to get up. His head was bleeding and everything." V31 was

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asked was any other staff outside supervising while you went upstairs. V31 stated, "No". V31 was asked, do you remember what R5 had on his feet. V31 stated, "He had on those slipper socks." V31 was asked, what you do if residents come out to the smoking patio and they are not dressed properly. R31 stated, "I send them back upstairs."

During an interview on 1/15/19 at 11:05 AM, R82 was asked if staff always supervise smokers on the smoking patio. R82 stated, "No staff is not always out there."

On 1/16/19 at 10:00 AM, during an interview with V21 (Social Service Director), V21 was asked, if the smoking patio is always supervised. V21 stated, "Yes, there is always someone out there with the residents."

A review of the facility policy dated 11/28/16, titled "Smoking Policy" reads as follows, "All residents will be under supervision while smoking. A. Residents must remain within eye sight of the smoking monitor."

A review of R5's physician's telephone orders dated 1/14/1, reads as follows, "Send resident to (Local hospital) for fall and CT (Computerized Tomography) of head".

A review of the hospital emergency room "Discharge Instructions" dated 1/14/19, reads as follows, "There is an uncomplicated diagonal laceration located over the parietal scalp which is 1 centimeter in length. This wound should be rechecked in 2 days. There is an uncomplicated diagonal laceration located over the parietal scalp which is 1 centimeter in length. Sutures to this wound should be removed in 7 days."

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A review of the facility incident report dated 1/14/19 reads as follows, "Other info- Resident outside on patio wearing nonskid footies without shoes."

A review of R5's most current "Fall Risk Screen" dated 1/8/19 rated R5 with a score of "75". The Fall Risk Screen tool indicates a high risk for falls is a score of 45 and higher.

A review of R5's fall occurrences as listed on the care plan dated 1/15/19 indicates the following: The resident is high risk for falls related to diagnosis of end stage renal disease, syncope, generalized muscle weakness, as well as a history of falls.

- o 3/5/18
- o 4/13/18
- o 4/16/18
- o 4/17/18
- o 6/1/18
- o 6/18/18
- o 8/12/18
- o 12/22/18
- o 1/6/19
- o 1/14/19

Care plan interventions include the following: "Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair.
A review of the care plan with an initiation date of 1/10/19 with a focus of: resident is a smoker, reads as follows; "The resident will not smoke without supervision through the review date. The resident requires "SUPERVISION" while smoking."

The facility failed to ensure that a resident identified as a 'High Risk" for falls was supervised

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while in a resident area (smoking patio), which requires staff supervision. While unsupervised, the resident had a fall incident and was assisted by other residents on the smoking patio. The resident sustained a head injury, which required a transfer to the hospital, for emergency medical treatment.

On 01/14/19 at approximately 10:30 am, In R248's room four disposable shaving razors noted on the bed side table. V2 DON (Director of Nurses) stated the disposable shaving razor should not be left at the bedside table.

01/14/19 10:33 AM R82 was observed to have three disposable shaving razor blades at the bedside. V23 RN (Registered Nurse) who was present at the time, stated "The CNAs who take care of the resident left them there and I will have to talk to them about it for safety reasons."

01/14/19 10:36 AM, in room 222 one disposable razor noted on the table. V2 stated it should not be left there. V2 stated"Tthey are kept in the clean utility room for safety reasons."

On 1/14/19, 1/15/19 and 1/16/19 three days of the survey the facility was unable to present any policy on hazards or the facility protocol on shaving equipment. V2 stated they only have a policy on Incident and Accident, which did not cover this issue.

On 1/16/19 as at 4:00 pm, V1 (Administrator) could not accurately provide the list of the residents who are actively mobile on the 2nd floor; and unable to identify residents who would be at risk.

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